

**Date:** [Insert Date]

**To:** [Insurance Company Name / Landlord / Homeowners Association]

**Attention:** [Contact Person or Department]

**Address:** [Insert Address]

**RE: Medical Necessity for Wheelchair Ramp Installation**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

**Policy/ID Number:** [Insert Number]

To Whom It May Concern,

I am writing this letter on behalf of my patient, [Patient Name], to formally document the medical necessity for the installation of a wheelchair ramp at their primary residence located at [Insert Patient Address].

**Diagnosis and Physical Limitations:**

[Patient Name] is currently under my care for the following medical condition(s): [List Diagnoses, e.g., Multiple Sclerosis, Spinal Cord Injury, Osteoarthritis]. As a result of these conditions, the patient suffers from [List Symptoms, e.g., severe mobility impairment, inability to climb stairs, high risk of falls, partial paralysis].

**Medical Necessity:**

Due to the aforementioned physical limitations, the patient is primarily dependent on a [Manual/Power] wheelchair for daily mobility. Currently, the presence of stairs at the entrance of their home acts as a physical barrier that prevents the patient from safely entering and exiting their residence.

A wheelchair ramp is medically necessary to:

1. Provide safe and independent access to the home.
2. Prevent further injury or falls associated with attempting to navigate stairs.
3. Allow for transportation to essential medical appointments.
4. Ensure a safe means of egress in the event of an emergency.

**Recommendation:**

I am prescribing the installation of a semi-permanent or permanent wheelchair ramp that meets ADA standards to accommodate the patient's mobility device. This modification is a vital component of the patient's long-term care plan and is required for their safety and functional independence.

Please contact my office at [Phone Number] if you require any additional information or documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Medical License Number]

[Practice Name]

[Phone Number]